| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155298 | A. BUILDING _____ B. WING _____ | C 08/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CAMBRIDGE MANOR NURSING & REHABILITATION CENTER** | **8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00113957 and IN00114129.<br><br>Complaint IN00113957-Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00114129- Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey date: August 16, 2012<br><br>Facility number: 000195<br>Provider number: 155298<br>AIM number: 100267690<br><br>Survey team:<br>Charles Stevenson, RN<br><br>Census bed type:<br>SNF/ NF: 67<br>Total: 67<br><br>Census payor type:<br>Medicare: 2<br>Medicaid: 54<br>Other: 11<br>Total: 67<br><br>Sample: 3<br><br>Cambridge Manor Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00113957 and IN00114129.<br><br>Quality review completed on August 17, 2012 by | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 000 | Continued From page 1<br>Bev Faulkner, RN | F 000 | | |